Suffolk County Department of Social Services
FCSA Child Care Bureau

VERIFICATION OF RESIDENCE

Applicant/Recipient Name: _____ ***Case #:*** _____*(if applicable)*

IMPORTANT: This form is to be completed by a professional person who knows you and your family. This person may be a physician, attorney, social worker, landlord, member of the clergy, or other professional. **DO NOT FILL OUT YOURSELF. DO NOT LET A FAMILY MEMBER FILL OUT. DO NOT LET A NOTARY FILL OUT.**

List ALL Adults residing in home		
Line #	**Last Name:**	**First Name:**
1		
2		
3		
4		

List All Children in Family		
Line #	**Last Name:**	**First Name:**
1		
2		
3		
4		
5		
6		

I _____, do hereby state that the above named
(print name of professional filling this out)

Individual(s) live at: _____.
(address of client)

_____ _____
(Signature of Professional) (Date Signed)

Signer's Profession: _____ Signer's Phone #: _____

Signer's Address: _____

CCB-6010-002 (Rev. 01/2015)

P.O. BOX 18100
HAUPPAUGE, NY 11788-8900

www.suffolkcountyny.gov/departments/socialservices
Child Care Unit Fax #: (631) 854-3331